

Child Health Policy and the Next American Presidency

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It's really wonderful to be here today. I don't get to the University of Michigan very often. In fact, I was reminiscing with Dr. Siefert that I believe that the last time I was here was about 13 or 14 years ago. It is particularly propitious to be giving this lecture here now, and I am very grateful to Dr. Meister for funding this lectureship in one of the great battleground states for the next American Presidency. It is of course a great honor to have been asked to give the Fauri Lecture, since Dean Fauri was one of the giants in social welfare policy.

My speech today focuses on the topic of child health policy and the next American Presidency. There could not be a more meaningful state in which to present this lecture, since, as I gathered during my cab ride this morning from the airport, the race is seesawing back and forth in Michigan. This state thus plays a particularly pivotal role in determining who will control child health policy for the next four to eight years.

I think that one of the more remarkable aspects of this election has been the dramatic role that national health policy has played. Indeed, if one had asked most political and polling experts only months ago about the importance of health policy in the election, they would have indicated that health care was not a major issue. Indeed, Dr. Robert Blendon, who directs the Kaiser Family Foundation's health polling efforts at Harvard, had only weeks before the first debate dismissed health as a significant policy topic in the 2000 Presidential election.

What a difference a matter of weeks makes. In the past two debates, the most electrifying moments have centered on health policy, and one of those has specifically focused on child health policy, a virtually unheard-of turn of events. During the first debate, Medicare drug coverage dominated the discussion. But children were the galvanizing subject in last week's debate, particularly regarding the question of the nation's commitment to ensuring the health coverage of children.

I begin this talk with a statistical baseline to make sure that we are all on the same wavelength with respect to the issue of child health policy today. I want to start with a quick overview of children's health insurance status in 1999. These data are from the United States Census Bureau's recent release of health insurance data. They show that in 1999, about two-thirds of all children had private insurance. Private insurance for children is overwhelmingly derived through employer-sponsored coverage; very few children have private coverage through sources other than their parent's employers. The Census Bureau's ability to identify the sponsor of coverage probably has been severely constrained in recent years with the rise of Medicaid managed care and private coverage purchasing through the State Children's Health Insurance Program (SCHIP). Under managed care, Medicaid and SCHIP beneficiaries possess managed care membership cards that look like anybody else's evidence of enrollment and thus many families may no longer know whether their coverage is public or private. But for now we can assume that the census numbers are right and that employer-sponsored coverage leaves out a considerable number of children. The data also show that in 1999, one child in five was enrolled in Medicaid, and 14 percent were uninsured.

The proportion of children with coverage and the type of coverage they have both vary tremendously by income. The overall rate at which children are uninsured hovers at about 14%. But among poor children, one in four is uninsured, an issue that has garnered a lot of attention in recent years because of the fact that comprehensive public coverage is now available to all but a small number of children under age 18. We now make it possible for virtually all low-income children to have coverage in the U.S. There are certain children who are not aided, I might hasten to note, particularly children who are not U.S. citizens who have arrived in the U.S. within the past five years. But putting aside that small and exceedingly important group, poor children are pretty much universally entitled to coverage through Medicaid.

The proportion of uninsured children varies significantly by race and ethnicity. It is striking that children who are most likely to be poor, Black and Hispanic children, are also the most likely to be uninsured. Again, this is a bit of a paradox, given the prevalence of public insurance programs, and should be understood as evidence that these programs are not working the way they should.

Given what insurance is meant to do, it is important to look at insurance data over long periods of time, not on a snapshot basis. If one looks at children's coverage over a 28-month period, it is evident that only about 70% of children have continuous coverage. Children move in and out of a very pluralistic system. We can think of it as sort of rotating children through public insurance, private insurance, and no insurance, depending on the working arrangements that their parents may have at any given moment and the amount of family income they have. This rotation in recent years has been expanded to beyond just Medicaid and employer coverage. In many states this movement is through Medicaid, employer coverage, and the state children's health insurance program, although the program is too new to have this rotation captured in data. As a result, children's propensity to be propelled through various insurance arrangements is, if anything, going up and not down, because we have created more coverage possibilities.

The insurance data must be understood against family income. Over the past half century there has been a tremendous and important decline in poverty among older Americans. With declining poverty rates have come a vastly improved standard of living. This decline in poverty among the aged and the improvement in the standard of living must be understood as one of the great social welfare achievements in modern U.S. history, along with the establishment of universal health insurance.

At the same time, the picture is much grimmer for children. In 1959, children enjoyed a standard of living, as measured by their family income levels, that was slightly better than that for the elderly. Children reached their best standard of living, again as measured by family income, in 1970, when poverty rates reached their lowest point. But today childhood poverty, while not as deep as it was in the 1950s, is a significant problem that compounds all other measures of children's well-being. Today, one in six children in the United States is poor. Furthermore, what we think of as mainstream insurance (namely employer-based coverage) is in fact not the mainstream system at all for some 35% of all children.

Because the Census Bureau changed its statistical methods for collecting and reporting on insurance data in the mid-'80s, we can examine trend data only from 1987 onward. If I had matched data from the 1977 National Medical Care Expenditure Survey with more recent updated data from the same survey series, what you would see is that children reached their apex within the employer-sponsored health insurance system by the mid-1970s. At that point, slightly more than 70% of children, again not a great number, had employment-based coverage. By the mid-1980s, after a period of great inflation followed by the worst recession since the Great Depression, the proportion of children with employment-based insurance had dropped to 63.9%. It dipped down a little bit further during the recession of the early 1990s. But what is shocking is that during the greatest period of economic expansion in the U.S. in modern times, with nearly full employment, the proportion of children covered by employer-based coverage is lower than where it stood 20 years ago. Census data indicate that where children's coverage is concerned, the nation has returned to the insurance levels it enjoyed 15 years ago.

The Medicaid statistics are equally disturbing. Until the mid-'90s, Medicaid was performing just the way you expect the program to perform as a public insurance complement to the "mainstream" employment-based insurance system.

Thus, as employer coverage dipped, Medicaid coverage grew. This occurred both because of Medicaid restructuring that began in the mid-1980s as well as because economic times were bad and as poverty grew, so did the number of children who qualified for Medicaid.

By the latter part of the 1990s, and with no appreciable changes in poverty levels or employer coverage levels, the Medicaid numbers began to fall following the advent of welfare reform experiments in the states. This trend is completely contrary to Medicaid's historic performance, particularly in light of the expansions. There is a good deal of speculation about these numbers, both on the Medicaid and the employer side, ranging from the concentration of young children in the poorest families, to growth in the number of single parent families, the increasingly attenuated nature of employment in relation to compensation and the growth in contractual jobs that may not carry fringe benefits as part of a compensation agreement. Other experts focus on changes in the behavior

of smaller employers, who have always been much less likely to offer coverage. Furthermore, in recent years, the proportion of small employers who offer coverage has gone down and the proportion subsidizing that coverage has also remained low.

Whatever the cause, the net effect of all the combined factors is that this system does not work well for children. The state children's health insurance program has helped a small amount but also has served to underscore children's growing reliance on public insurance, where the subsidy for the coverage comes from direct government grants rather than through tax exemptions, the traditional method by which the nation has subsidized health coverage for non-elderly persons for more than a half century. From a legal point of view, a subsidy is a subsidy, and thus, while different types of subsidies may produce different economic or operational results, the shift from indirect coverage through tax-subsidized employee benefits to direct coverage through grants to states may be fine. The point should not be missed, however, that as a matter of public policy, the nation increasingly is electing to cover its children through a direct and individual-based grants process, not through tax policy. The other point that should not be lost is that from a financial point of view, the impact of government grants is no greater. Data from the United States Treasury suggest that the federal government alone invests about \$100 billion annually in health care through tax expenditures (i.e., lost revenues), making this category of federal spending a rival to the federal Medicaid and SCHIP programs combined.

This shift to direct government spending on child health and the concomitant decline in tax expenditures reflects a huge shift in public policy. It is easy to describe the current situation but when I began my own work on Medicaid reforms for children in the 1970s it was virtually politically impossible to suggest that coverage should be set at half the federal poverty level. Today, we routinely expect that states will set coverage at 200% of the federal poverty level and admonish them when they do not do so.

With this statistical and policy baseline in mind, we can turn to the question of child health policy. As this overview itself suggests, when we think child health policy we think coverage. Furthermore, we tend to focus on *any* coverage and do not question the adequacy of coverage and are too willing to accept at times a medicalized model of third-party financing. Furthermore, we tend to equate health care financing with health insurance, even though by doing so we effectively insist on using the most costly and inefficient model we can imagine to pay for the services that children need most: primary and preventive services. Many of these services are not only less expensive to fund through alternative means but may in fact be of better quality when furnished outside of a medical system, such as through public health nursing. Moreover, we put financing dollars for low-cost pediatric care into a spending mechanism that appears to be particularly susceptible to health care inflation.

Even if we confine ourselves to the issue of third-party financing, we spend far too little time on the appropriateness of what we buy. The issue of coverage has two dimensions to it: having any coverage and having appropriate coverage. As important as who is covered is the question of for what. In the case of Medicaid and, to a lesser extent SCHIP, the vision of the program is actually not an insurance vision at all. It is a third-party financing vision, which means the program is flexible enough to pay for all services that go beyond insurance and that are health-related or health-promoting or preventive in nature. The programs also will pay for services furnished in unconventional settings such as community clinics and health departments and schools, and may transcend traditional medical care.

The insurance model in the U.S.—and this even goes for HMO-style managed care—is very different. The vision of insurance is, of course, insurable risk. And while HMO-coverage contracts may include some preventive benefits, in fact the model of financing in an HMO is insurable risk. It has to be. Insurers are at financial risk. As a result, coverage is very limited. People are covered only if they suffer from an illness or injury, meaning that children with cerebral palsy would fall outside of the limits of contracts that are restricted to acute illnesses and injuries. Many contracts cover only those treatments that show a significant improvement in functioning. This means that children who need care to prevent deterioration in functioning, to promote optimal growth and development in light of a long-term disability, may be excluded from the scope of the coverage. The textbooks are

replete with cases of coverage denied to children with chronic, disabling conditions because they fall outside the scope of a contract or their needs are beyond insurance norms.

Beyond the issue of coverage lie the issues of access and community benefits. These are critical dimensions of a national child health policy, and yet they are seriously lacking.

In truth, the U.S. doesn't have a child health policy arrived at through deliberate planning. Coverage is a chance proposition. Access to care for millions of children is shaky. And certain fundamental services for children that should be viewed as part of the normal fabric of life rather than medical care, are lacking from many communities.

In the case of health care access, millions of children are at risk. In addition to children who are at risk for medical underservice simply because their health status puts them outside of the reach of insurance limits, there are children who literally physically do not have access to care. Of America's 49 million Americans at risk for medical underservice because they live in areas with high health problems and limited providers, 12 million are children. And there are only enough community-supported clinics in those areas to reach about a quarter of the underserved population in the U.S. This doesn't take into account state and community efforts to fill in with free clinics and other community interventions. But if we consider only federally funded health centers, which tend to dominate primary care and eclipse state investments, we see that there are only enough to reach about a quarter of the underserved population in the U.S.

Children with public coverage have significantly greater access to care than uninsured children. But among uninsured children, there are certain groups who face particularly shocking health care barriers in many communities. These include children of migrant workers, children of newly arrived immigrant families, and children who are homeless. These children have received absolutely inadequate attention. And in the case of immigrant children, recent policies restricting eligibility for Medicaid have only served to make the barriers worse.

Beyond the question of access lie community benefits. There are certain health services—and this is true for people of all ages, but particularly children—that simply lie outside the realm of normal third-party financing discussion constraints. I am an insurance lawyer. I can tell you that there are certain services that simply do not belong in this part of the health policy discussion. Examples are school clinics, services for children in childcare or Head Start, and infant growth and development services for families who face health and social risks, and who need community workers and community preventive health interventions. These are services that should be funded as a public good and simply made available, not just out of altruism and not just because the service is beneficial, but because, quite frankly, they don't belong in an insurance model. It would be very costly to fund them through insurance. Why? Premiums are built into insurance costs, which means that not only does the financing model not encompass the types of health care providers that are needed for community services but moreover, every dollar spent has to carry the added financial weight of a premium payment. Think of it this way. What is the risk that a baby needs a checkup? The answer is none. It's a 100% certainty that a baby will need a checkup, that a school in a poor community will have sick children in it, that Head Start children will need their hearing examined. One does not insure those kinds of things. It's an oxymoronic discussion.

In sum, community benefits are an aspect of child health policy that simply does not receive enough attention, because we are understandably fixated on our insurance problems. The discussion of community benefits is made even harder by the fact that those whose specialty and expertise is insurance are not forthright enough about the limits of the model. The model is a limited one for sensible reasons. Why should we charge families a premium for services that we know they need to have and should be underwritten on a community-wide basis?

This brings me to the final portion of my lecture. Where are the candidates in all of this? To answer this question, I went to the Gore and Bush websites to see what they had to say. What I present to you is exactly what their platforms contain, in the order in which they presented it.

Let's begin with Vice President Gore. At his website, the number one issue is Medicare, including both a drug benefit and program improvement. This tells me that he has targeted this issue, obviously, as an issue of the highest caliber for his health policy. If he is president, this is the issue that he will come out of the box with in the case of health policy. The Vice President's second issue is a patient's bill of rights, a very, very important set of issues having to do with the integrity of insurance for all of us. The third issue, interestingly, is expanding coverage to all children by raising the SCHIP upper income limit from 200% to 250% of the federal poverty level, again evidence of a commitment to expanding direct public expenditures on child health. I might note that his proposed SCHIP expansions duplicate what already can be done under Medicaid. Ironically therefore, the Vice President has proposed duplicative spending that obligates billions of dollars in federal funding to insurance costs, funding that could have been invested in community health benefits, access improvements, or other pressing health-related matters such as childcare or early childhood development. If there is a tragedy in SCHIP it is that Congress spent \$40 billion over 10 years on a program that duplicates what Medicaid already does or could have been revised to allow states to do, thereby freeing up \$40 billion to go into childcare or housing or educational improvements or family income supports. The answer for this duplication lies in state resistance to using the traditional Medicaid program to reach near-poor children, but there were other ways than wasting \$40 billion in my view of addressing this.

Governor Bush's proposals are in certain respects more interesting. At the Bush website you will notice that Medicare reform, including drug reform, is not his first priority in health. His first priority is a refundable tax credit to help make health coverage more affordable to working families. This proposal is in keeping with a tradition of using the tax code to subsidize employer coverage and it makes at least as much sense as direct subsidies from a purely financial point of view. The governor also proposes to improve small employer purchasing supports, relax what are already pretty relaxed SCHIP rules, and generally try to nurture more affordability and coverage.

What we see is that both Vice President Gore and Governor Bush very importantly recognize family coverage as pivotal in this whole debate. The Vice President would achieve this goal through expansion of the SCHIP program to cover working families, a technique already possible through Medicaid. Governor Bush would target tax credits at the same group of families, again ignoring Medicaid in favor of a more market solution. But neither has a problem with calling for the subsidization of low- to moderate-income families who do not derive these subsidies from their employers. In this respect, they offer identical frameworks.

Governor Bush goes on, however, to make access to care a principal feature of his platform. He calls for a major expansion of the Community Health Centers Program, and this combination of insurance and access reforms suggests an appreciation on his part of the need to couple insurance and access, although many worry that his health center expansion is offered in lieu of coverage.

In the end, what do these two positions tell you? In my view, they suggest that while they appreciate some or more elements of a policy, neither has what I would call a national child health policy with all three dimensions—coverage, access, and community benefits. Moreover, neither talks about the integrity of insurance or the problem of under-insurance for children or adults with long-term and chronic illnesses. And this has to do with the failure to understand the true nature of the insurance problem in the U.S., which is that a model of payment for occasional and unforeseen risks is not a health policy.

Underlying the limits of their policy vision is another issue that in the U.S. always lurks below the surface where children are concerned: the class between public policy regarding children and the responsibilities of families. This is an area of historic difficulty in the U.S. When should government intervene, and how, where children are concerned? At the same time, it is clear that however tentative we may be about health care access as a matter of public policy rather than family responsibility, we now see that even the most responsible moderate-income and lower-income families cannot cover their children.

There are, of course, many signs of hope. It is quite astonishing that child health policy has reached the point that it has. There are certainly signs all around us of a growing government acceptance to help with financing and subsidies and the underwriting of access in underserved areas. We are awash in a range of sociodemographic issues that are causing the government to have to spend more and more time thinking about these problems, which is a very good thing. The more we insist on living in ways that require having a deliberate child health policy, the better off we'll all be. And so as families work, as social norms change, as our expectations of what our communities and the government should do for us and with us and to help us, then public policy changes as well.

I think that it is notable that children have become a measure in this campaign of accountability, and their bad treatment the most powerful metaphor of "the Texas syndrome": that is, George Bush's questionable abilities in governing. Ironically, I might note, the greatest indictment of Texas ironically, is not its slow implementation of SCHIP, but its terrible mismanagement of Medicaid over many decades, which has left millions of children outside of the program and millions more poorly served.

I'm not in the habit of making predictions, but I'll make a few of the type that are so vague that you can't possibly be wrong. I guarantee you that health will once again be a huge issue in the 107th Congress and that the issue of coverage and the issue of coverage for children will be debated once again. The most basic question is whether we have eked out the incremental improvements we can make and is it time for a true national child health policy? My final prediction is that the magnitude of government's response to this question is a matter that is absolutely within our control. I thank you.